SENT VIA EMAIL OR FAX ON
Mar/19/2012

Independent Resolutions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Mar/16/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
T/11-L/1 Open 360 Fusion, 3 days Inpatient Stay

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Orthopedic spine surgeon, practicing neurosurgeon

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)

[ ] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
OD Guidelines
Utilization review determination notification 01/13/12
Preauthorization review 01/13/12
Utilization review determination notification 02/15/12
Preauthorization review 02/14/12
Behavioral medicine evaluation 07/14/11
New patient consultation and follow-up 05/17/11-12/09/11
MRI lumbar spine 11/30/11
Operative report epidural steroid injection right L4-5 03/21/11
Office notes 12/01/10-03/02/11
Preauthorization request 01/09/12
Physical therapy initial evaluation and progress notes 05/26/11-06/22/11
Designated doctor evaluation 01/10/11
Office notes 02/15/11-04/06/11
MRI lumbar spine 08/31/10
EMG/NCV 10/08/10
Computerized muscle testing and range of motion 09/22/10
Appeal preauthorization request 02/01/12

PATIENT CLINICAL HISTORY SUMMARY
The claimant is a female who was injured on xx/xx/xx when she slipped and fell on ice. She complains of low back pain and right knee pain. MRI of lumbar spine on 08/31/10 reported

broad 1 mm disc protrusion at L4-5 with 2 mm left posterolateral component with no canal stenosis or foraminal narrowing. The claimant underwent arthroscopic knee surgery on 03/07/11. The claimant was treated with physical therapy and tried injections which worsened her symptoms. Medications include Hydrocodone and Mobic. Electrodiagnostic testing on 10/08/10 was essentially normal study without evidence of lumbar radiculopathy. There was evidence of right peroneal mononeuropathy of uncertain etiology. Repeat MRI was performed 11/30/11 which revealed compression fracture of superior endplate of T12 with retropulse bone into anterior aspect of central canal which appears old in origin. This creates mild relative central canal stenosis. At L4-5 there is minimal broad based disc bulge causing minimal effacement upon the anterior aspect of thecal sac. At L5-S1 there is minimal central focal disc bulge causing minimal effacement upon the anterior aspect of thecal sac. The claimant was seen on 12/09/11 by and noted MRI scan shows mild disc desiccation at L4-5 but more of problem is T12 vertebral body. There is significant compression fracture with loss of about 50% of anterior height. There is also transverse fracture line through the upper portion of the vertebral body which has caused this fragment to also be retropulsed into the spinal canal. In addition the fracture has caused a kyphotic segmental deformity at this level. The claimant was recommended to undergo corpectomy of the T12 vertebral body with expandable strut cage and pedicle screw instrumentation to realign, correct the kyphotic deformity, and create tension band effect to reduce the retropulsed fragment. Due to the fact she has a retropulsed fragment it was felt that a methyl methacrylate type procedure is not going to benefit her, and she would still be left with kyphotic deformity at this level.

A request for T11-L1 open 360 fusion with three day inpatient stay was reviewed on 01/13/12 and non-certification was recommended. It was noted that the claimant had completed four physical therapy sessions to date, but it appears the therapy was geared towards the claimant's complaints of low back pain and not more toward the mid back or thoracic region. Given the lack of information regarding specific treatments involving the claimant's therapy the request does not meet guidelines recommendations.

An appeal request for T11-L1 open 360 fusion with three day inpatient stay was again non-certified as medically necessary. Reviewer noted that medical records demonstrate the claimant has been worked up for low back pain. She does not demonstrate significant pain at the T12 area and this is considered an old fracture. The psychological evaluation was not specific for fusion surgery. The records indicate this was for symptoms of anxiety and psychotropic drugs were recommended. However, no psychological evaluation was performed clearing this claimant for fusion surgery. The request was determined as not medically necessary.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION

Based on the clinical information provided, the request for T11-L1 open 360 fusion, three day inpatient stay is not supported as medically necessary. The claimant is noted to have sustained an injury when she slipped and fell on ice. Initial MRI on 08/31/10 showed L1-2, L2-3, L3-4 and L5-S1 no disc herniation, canal stenosis or foraminal encroachment. At L4-5 there is a broad 1mm disc protrusion with a 2mm left posterolateral component, with a zone of hyperintensity suggesting the disc protrusion is acutely irritated and edematous. The claimant underwent right knee surgery. She continued to complain of low back pain and was treated with injections without significant improvement. Examination of the lumbar spine on 03/02/11 showed point tenderness to palpation of the paraspinous musculature. There was positive percussion from L4 to L5-S1. Straight leg raise was negative. Deep tendon reflexes were 2/4 bilaterally. The claimant was unable to toe or heel walk. There was decreased sensation at L4-5 and L5-S1. Right L4-5 epidural steroid injection was performed on 03/21/11. The claimant was seen by for new patient consultation on 05/17/11 with complaints of low back pain rated 10 and leg pain about an 8. On examination the claimant had normal gait pattern and tandem gait pattern. She could walk she could stand on toes and heels without difficulty. She had 5/5 strength in the upper and lower extremities. Sensation was grossly intact in the upper and lower extremities. There were no long track

signs. She has a negative log roll. Right leg is in a brace due to recent surgery. There is tenderness about the region of L4-5 with pain more on the right than on the left. She has pain in both flexion and extension. Impression at that time was low back pain secondary to spinal instability at L4-5 with listhesis and lumbar disc disease. Repeat MRI on 11/30/11 revealed minimal disc bulging at L4-5 and L5-S1 causing minimal effacement of the anterior aspect of the thecal sac. Also noted was compression fracture of the superior endplate of T12 with retropulsed bone into the anterior aspect of the central canal. It was noted this appears old in origin, and creates mild relative central canal stenosis. Based on the data provided, it does not appear that the claimant has had treatment directed towards the mid/thoracic spine. There was no indication of compression fracture on initial MRI performed 08/31/10. Records indicate that the claimant was worked up for a low back and according to follow-up on 06/28/11 was anticipating a minimally invasive fusion at L4-5. Given the current clinical data, medical necessity is not established for the proposed surgical procedure and previous denials should be upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)